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THE CHILD HEALTH INSURANCE PROGRAM: EARLY IMPLEMENATION IN SIXSTATES

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CHAPTER I: EARLY IMPLEMENTATION OF THE CHILD HEALTH INSURANCE PROGRAM

Background

Research has demonstrated that children with health insurance coverage have greater access to medical care than those without coverage. On average, those with health insurance visit doctors more frequently than those without coverage. A 1993 survey, for example, found that of all children who had no physician visits in the past year, 39 percent were uninsured compared to 20 percent of children with private coverage. (See Exhibit 1.) Children with health insurance coverage pay fewer visits to the emergency room in an average year than those without coverage. Those with health insurance develop fewer chronic illnesses, and those they do develop are treated more successfully than the chronic illnesses of uninsured children.

Parents report that children with health insurance are able to obtain regular primary and preventive care. With the help of proper preventive care, including immunizations and regular check-ups, it is possible to identify children's problems as they occur, treat them as early as possible and avoid unnecessary complications. A common adage among health policy analysts, researchers, and service providers is, "Children are not little adults."

Recent trends in health insurance coverage have not been kind to the nation's children. The Census Bureau estimates that at least 10.7 million children lacked health insurance coverage in 1997, up from 9.8 million in 1995.1 The proportion of all children with no health insurance increased from 13.8 percent in 1995 to 15 percent in 1997. The proportion of poor children with no health insurance rose to nearly 24 percent in 1997, from 21.4 percent in 1995.2

The Medicaid program, begun in 1965, was designed to cover the health care costs of children and families in poor and near-poor households. For children, Medicaid, which includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program provides comprehensive benefits including preventive, primary, developmental and long-term care services to eligible children. Under current Federal law, States must cover all children up to age six with family incomes up to 133 percent Federal poverty level (FPL) and children age six and older and born after September 30, 1983, with family incomes at or under 100 percent FPL. Under this provision, States must phase in coverage one year at a time so that by September 2002, all children under age 19 living below poverty will be eligible.

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1 American Hospital Association, Campaign for Coverage: A Community Health Challenge, Washington, DC. Spring 1998.
2 U.S. Bureau of the Census, March 1996, 1998 Current Population Survey.

Insert Exhibit 1 Here (Bar Graph)

States have flexibility to extend Medicaid coverage beyond the Federal requirements and a number have done so.

However, even when there is expanded coverage, States have consistently fallen short of enrolling all children who qualify for Medicaid. The American Hospital Association estimates that as many as 4.3 million of the nation's 10.7 million uninsured children may be eligible for but not enrolled in Medicaid.[3] Reasons for the gap include inadequate marketing and outreach by State public assistance offices, families unaware of their eligibility, and families reluctant to apply because of the stigma they associate with Medicaid — a government assistance program too much like welfare. Recently, the gap in coverage between those eligible and those enrolled has increased even more.

One segment of the population that, historically, has been enrolled in Medicaid is families on welfare. Until recent changes, families with children who were receiving cash payments from the most prominent welfare program — Aid to Families with Dependent Children — were automatically eligible for Medicaid. The new welfare law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, separated Medicaid and welfare eligibility for the first time. Now families losing eligibility for cash assistance *may* continue to qualify for Medicaid under other eligibility categories. States are required to make a separate determination about Medicaid eligibility when a family no longer qualifies for cash assistance. However, many parents do not know about the possibility of continued Medicaid and workers often fail to provide them with appropriate information about their potential ongoing eligibility.

To help reduce the number of uninsured children and to increase their access to medical care Congress established, in 1997, a new Children's Health Insurance Program (CHIP) as Title XXI of the Social Security Act. Intended to supplement — not supplant — Medicaid, CHIP is designed to find and enroll "targeted low-income children" whose family income puts them above the Medicaid eligibility threshold, but below an income level that makes private health insurance premiums affordable. A targeted low-income child is one whose family income does not qualify for Medicaid, but is lower than 200 percent of the FPL — approximately $32,000 for a family of four, in 1998.[4]

The statute clearly requires States to first screen every child for Medicaid eligibility before determining eligibility for CHIP. In this way, Congress sought to ensure that every child is enrolled in the correct program and that CHIP would help increase the number of insured children across the nation.

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[3] American Hospital Association, *Campaign for Coverage: A Community Health Challenge,* Washington, DC, Spring 1998.

[4] States are permitted flexibility to set lower or, in some cases, higher income eligibility levels.

Key Requirements for CHIP

The law allows States to provide children's health insurance in one of three ways: 1) by developing a State-initiated plan for children's health insurance; 2) by expanding current State Medicaid provisions to incorporate more uninsured non-Medicaid children; or 3) a combination of both. The law further lays out options for the benefits package of CHIP programs in States choosing to implement a State-initiated program. Those States must provide benefits equivalent to one of the following: *benchmark coverage* (i.e., the standard Blue Cross/Blue Shield Preferred Provider Option, the health plan that is provided for State employees, or the HMO plan with the largest enrollment in the State); *benchmark-equivalent coverage* (any other health plan that is equivalent to the benchmark plans); *existing comprehensive State-based coverage* (coverage that already exists in another Statewide program in Florida, Pennsylvania and New York); or *other coverage approved by the Secretary of HHS*.

States are required to submit, for approval by the Secretary of HHS, a detailed plan of the proposed CHIP program. States need to include the following information in their State Plans:

- Type of program (State-initiated, Medicaid expansion, or a combination);
- Overview of current coverage for children and how the new plan will be integrated;
- Eligibility requirements and enrollment procedures;
- Outreach strategies to make the public aware of the new program;
- Cooperation between the program and other public and private insurance programs;
- A description of cost-sharing, (such as premiums, co-payments, and deductibles to be charged to families);
- Performance goals and measures;
- Procedures for data collection, assessment, reporting, and evaluation of the program; and
- Outline of the budget.

The law provides for higher Federal matching funds to States for CHIP than the regular Medicaid program. Because of this "enhanced matching rate" for CHIP, additional provisions were added to ensure that Medicaid eligible children are enrolled in Medicaid and not CHIP, and that CHIP coverage does not substitute for private coverage. These potential substitutions of coverage are called "crowd-out."

See the sections in this chapter on Federal/State Financing and Crowd-out Prevention for additional details on the statutory requirements and HCFA guidance to States.

The Study

The Assistant Secretary for Planning and Evaluation(ASPE) in the Office of the Secretary, U.S. Department of Health and Human Services(HHS) commissioned the American Institutes for Research to conduct this study — intended to be one of the earliest studies of CHIP implementation.

Purpose

ASPE commissioned in the spring of 1998 a study of the early implementation of CHIP. The study was designed to understand and document the decisions in six States regarding the:

- ❖ planning process;
- ❖ key factors affecting the program design in their initial plans submitted to HHS;
- ❖ CHIP program design as a separate State-initiated program, a Medicaid expansion, or a combination;
- ❖ choice of income eligibility levels;
- ❖ parameters of State-initiated health insurance programs implemented prior to CHIP; and
- ❖ implementation of specific features of their CHIP programs during the early months.

ASPE intends the resulting report and the information collected about different State practices to be shared with other States, particularly those that might not be as far along in their own implementation.

Issues Selected

ASPE staff chose, for its first study of CHIP, to focus on three issues of particular interest to them and the Health Care Financing Administration (HCFA), the agency administering the CHIP program. These issues are the States' efforts to:

- ❖ conduct marketing and outreach activities;
- ❖ implement strategies to mitigate against the possibility of publicly-provided insurance substituting for private insurance (commonly called "crowd-out")[5]; and
- ❖ collect data to evaluate their CHIP programs.

[5] See page 31 for a more complete explanation of crowd-out.

Methodology

The methods utilized for this study emphasized site visits to selected States, and in-depth interviews with gubernatorial, executive agency, legislative, and advocacy organization staff. The information presented in this report, unless otherwise noted, reflects data and opinions presented by each State's officials. AIR staff supplemented the interviews with reviews of relevant research on children's health insurance and access to care, State Plans, State design papers, outreach materials, applications and enrollment packets, and available State research reports. Staff also interviewed national experts on children's health, insurance coverage, welfare and Medicaid from the Center for Law and Social Policy, Institute for Health Policy Solutions, National Conference of State Legislatures, and National Governors' Association. State visits were conducted between September 1998 and January 1999.

The product of those interviews and reviews are individual State case studies of the early implementation of CHIP. The case studies generally reflect conditions in the fall and winter of 1998/99, except in Colorado where significant changes occurred later that warranted inclusion in that State's case study. All case study drafts were thoroughly reviewed for accuracy by State officials and advocacy staff who were interviewed.

States Selected

Selection of States to be the subjects of site visits and case studies was a group effort. In June 1998, ASPE convened an informal working group of representatives from their own office and from other divisions in HHS including HCFA, the Health Resources and Services Administration, Agency for Health Care Policy and Research, and Administration for Children and Families.

The group determined that they would select States from among those with plans approved by HCFA, as of June, 1998, that represented a mix along the following dimensions:

- ❖ CHIP separate State-initiated CHIP program vs. Medicaid-expansion, or a combination;
- ❖ Income eligibility level selected for CHIP;
- ❖ Those with and without pre-CHIP State health insurance programs for low-income families;
- ❖ Geographic distribution; and
- ❖ Demographic mix of the population.

Additional criteria for selection were that a State be far enough along in implementation (at least six months) that they have experiences to report, that

there is evidence they have (or have plans to collect) data for evaluation, and that they subsequently indicate a willingness to participate in the study.

Based on these criteria, the working group chose the following States for inclusion in the study:

- Colorado
- Massachusetts
- New York
- Ohio
- Oregon
- South Carolina

However, by the time the site visit was scheduled in South Carolina, the Governor had lost his re-election and it was difficult for the outgoing staff to participate. To replace South Carolina with another southern State, Alabama was chosen. Exhibit 2 displays selected characteristics of the six States and their CHIP programs.

Organization of the Report

Chapter I is a cross-case analysis of early implementation in the six study States. It opens with an analysis of common themes and contrasts in the States' legislative history and implementation of children's health insurance, Federal/state financing of the programs, and key players in the administration of CHIP. The remaining sections focus on analysis of outreach activities, crowd-out prevention strategies, and data collection and evaluation methods.

Chapters II — VII are devoted to an in-depth case study of each State. Each case study is organized in the following manner:

- History and Implementation
- Federal and State Financing
- Current Enrollment
- Key Factors in the State's Implementation
- Outreach
- Crowd-Out Prevention
- Data Collection and Evaluation

Featured in the section on outreach is advice the State officials chose to share with other States. Where available, the individual case studies provide Web addresses for other States to access outreach materials, application forms, research studies, and other reports.

Insert Exhibit 2 Here.

CROSS-CASE ANALYSIS

HISTORY AND IMPLEMENTATION

A history of pre-CHIP programs in most of these States helped smooth enactment of conforming legislation. Since five of the States were poised to expand health insurance for low-income children at the time that Title XXI passed, it made it easier to quickly conform with Title XXI provisions. In all six States, implementation of CHIP was smoothed by broad-based advisory boards of private and public officials, gradual expansion of coverage, and targeted outreach to known pools of CHIP-eligible children who were already enrolled in State-funded (pre-CHIP) public health insurance programs.

History

Precedence was helpful. Five States had a history of State-initiated programs to provide public insurance or direct services for uninsured, low-income children. Those States were able to build on existing administrative structures, outreach, enrollment practices, and provider networks.

- Colorado's history dates back to 1983:
  - The Colorado Indigent Care Program served poor, non-Medicaid residents of all ages through direct services by physicians and other fee-for-service providers who agreed to participate. The program focused on rural areas where residents were especially under-served and included outpatient and inpatient services.
  - The Colorado Child Health Plan (1990) originally provided free insurance for outpatient and preventive services to children under age nine in families with incomes below 185 percent of poverty.

- Massachusetts' history dates back at least to 1993.
  - The Children's Medical Security Plan was created to serve uninsured children. Over time, its age and income eligibility criteria expanded to cover children up to age 19 living in families ineligible for Medicaid.
  - The Insurance Reimbursement Program was proposed to offer tax credits to businesses covering 50 percent of the insurance costs for employees with incomes below 200 percent FPL. This proposal was later modified several times and it now provides direct subsidy payments to families through the Premium Assistance Program.

- New York's history dates back to 1990 with a program to provide primary, preventive care to non-Medicaid-eligible children under age 13. The

program subsequently expanded by adding children one year older each year until children up to age 15 were covered.

❖ Oregon obtained a landmark Section 1115 waiver in 1993 to ration care in its Medicaid program, Oregon Health Plan. The waiver allowed the State to expand eligibility to persons who would not have otherwise qualified for Medicaid coverage.

Timing was critical. Five States were poised to expand coverage for more uninsured, low-income children when Title XXI passed. This facilitated their efforts to comply with the new Federal requirements for Title XXI and allowed them to quicklv initiate CHIP.

❖ One State Legislature had just approved expanding the Healthy Start Medicaid program. Officials were ready to submit two amendments to their Medicaid State Plan and quickly prepared a CHIP State Plan. (Ohio)

❖ Another State Legislature passed a law further expanding Medicaid eligibility from 133 percent to 150 percent FPL for children through age 18. (Massachusetts)

❖ One State Legislature was poised to approve a Section 1115 waiver request to HCFA, expanding their pre-CHIP health insurance program for low-income, uninsured children to include inpatient and mental health services. This was, coincidentally, a big step in complying with XXI requirements. (Colorado)

❖ Yet another State Legislature had just approved moving Medicaid eligibility from 100 percent for children under age six to 170 percent for children through age 12. After Title XXI passed, the Emergency Board (which takes action when the legislature is out of session) quickly approved expanding the age eligibility to age 18 and redirected State matching funds from the planned Medicaid expansion to CHIP. (Oregon)

❖ A State wanted to expand its Child Health Plus program so Title XXI provided additional funds. State legislation was passed to enhance the existing program and to ensure its compliance with Federal requirements. (New York)

❖ Finally, one State Legislature was meeting for a special budget session just after Title XXI passed so CHIP was added to its agenda. (Alabama)

Bipartisanship prevailed. Interviews with legislative and executive officials testify to the bipartisanship that is a hallmark of both pre-CHIP and CHIP enabling legislation. Officials reported that "doing good things for children's health" is endorsed by both parties in all States.

Finding State matching funds was easier in some States than others. The strong fiscal condition of some States, and their attendant budget surpluses helped. In two States, statutory limitations on expenditure growth capped funding. In two States, increased tobacco taxes provided additional revenues for children's health.

- One State Legislature was already in a special budget session and the gubernatorial race created a climate to discuss "What is best for Alabama's uninsured children?" This facilitated consensus and a Joint Resolution passed authorizing $5 million for the initial State match. (Alabama)

- Two State Legislatures raised tobacco taxes, earmarking the projected receipts for children's health initiatives. (Massachusetts and Oregon)

- One State Legislature had already given the State Medicaid agency approval to expand their Medicaid program. When Title XXI was passed, the funds were already in place and the State was able to go ahead with the expansion and take advantage of the enhanced match. (Ohio)

- Two States face statutory limits on annual spending increases that limited CHIP funding. (Colorado and Oregon) In one of these States, the program also relies on private funding sources to supplement State appropriations. (Colorado)

States' experience with Medicaid played a role in the debates in two State Legislatures.

- One State Legislature chose the Department of Public Health, rather than the Medicaid agency, to administer its CHIP program. At the time, the Medicaid agency was facing a serious shortfall and historically, the agency has little support among legislators, health care providers, and child advocates. (Alabama)

- Another State Legislature was concerned about an earlier time when the Medicaid costs escalated. At that time, the legislature voted to drop the Medicaid program and while the governor vetoed the bill, legislators had continued concern about the program's impact on the State's statutory annual limit on spending increases. For this reason, a Medicaid

expansion was never considered as an option for the State's CHIP program. (Colorado)

Implementation

Advisory groups helped some States secure buy-in from a wide group of interested stakeholders. Through a variety of mechanisms, private sector CEOs, physicians, family representatives, and executive agency officials helped design programs and built broad support among Governors, legislators, advocates, and other stakeholders.

- A Children's Health Insurance Program Commission helped plan a new State program. Chaired by the State Health Officer, Commission membership included State legislators, executive agency staff, and non-profit representatives. The commission received help from an Advisory Council comprised of stakeholders from a variety of constituencies. (Alabama)

- One State convened a Policy Board that receives input from design teams and work groups on specific issues. The Policy Board includes the CEOs of Kaiser Permanente, Blue Cross/Blue Shield, the State branch of the country's largest private retirement fund, the State American Academy of Pediatrics chapter, Valley-Wide Health Services, a pediatrician from University Hospital (who played a key role in Colorado's earlier State children's health insurance programs), and the executive directors of four State agencies. The Board also includes a parent whose children are enrolled in the Colorado Children's Health Program. The Board recommends policy on eligibility, benefits, cost sharing, managing HMO contracts, reporting and evaluation, and quality assurance. Design teams and work groups, with staff from several State agencies, report to the Policy Board. (Colorado)

- One Governor created a Task Force of 17 members representing health care providers, consumer advocates, businesses, State representatives, public health agencies and private health care plans. The Task Force met ten times during a five month period to develop recommendations for the Governor on Phase II — the expansion of CHIP to 200 percent FPL. (Ohio)

- A State Health Council was created by the State Legislature to recommend policy for the State Medicaid program and, later, CHIP. The Council consists of nine members of the public appointed by the Governor. (Oregon)

Children's advocacy organizations in all six States substantially influenced the planning and implementation of CHIP. They helped influence the design of benefit packages, advocated for low or no cost-sharing by families (premiums and co-payments), collaborated on outreach strategies and, in some cases, encouraged States to collect specific types of data.

Implementation is proceeding in phases in all six States. Some are first expanding their State-initiated programs and expanding Medicaid later while others are doing the reverse. Most States, but not all, are planning an employer buy-in program for a later phase.

❖ Two States are expanding Medicaid during Phase I. (Alabama and Ohio) One has already implemented a separate State program in Phase II and is considering a Phase III to enhance benefits for children with special health care needs through a CHIP Plus program. (Alabama)

❖ One State's Phase I expands its State-initiated Colorado Child Health Program (CCHP) into CHP+ while working to resolve issues to implement an employer buy-in program in Phase II. No Medicaid expansion is planned. (Colorado)

❖ Another State simultaneously expanded Medicaid eligibility and its State-initiated program (Children's Medical Security Plan) in' the summer of 1998. The Premium Assistance Program (subsidizing employer premiums) was to begin in January 1999, starting with companies having less than ten employees and later expanding to cover employers with less than fifty employees. (Massachusetts)

❖ One State expanded its State-initiated program (CHPlus) first, beginning in January 1999. Later, the income eligibility will increase for Medicaid. (New York)

❖ One State's Phase I expanded Medicaid to cover eligible children up to 150 percent FPL and Phase II awaits legislative approval of Task Force recommendations to cover children up to 200 percent FPL. Phase II, although not a Medicaid expansion, plans to use the Medicaid (HealthyStart) infrastructure to administer the new program. (Ohio)

❖ Another State's Phase I implemented a Medicaid "look-alike" program, adding teenagers up to 170 percent FPL. Phase II-A will try to link the look-alike program with an existing State-initiated premium subsidy program. In a potential Phase II-B, the State would request a waiver to work with its only State Health Insurance Purchasing Cooperative to encourage small employers to offer health insurance with help from State premium subsidies. Phase III may have a waiver request to reimburse

community-based clinics for direct services to children who are difficult to reach with CHIP. (Oregon)

FEDERAL/STATE FINANCING

Title XXI of the Social Security Act authorizes $24 billion over five years for CHIP with specific allocations to each State[6]. The formula for allocating funds is based on each State's share of the nation's low-income uninsured children in families with income below 200 percent of the Federal poverty level (FPL), adjusted for a geographic health care cost factor for each State. Federal matching contributions are called the "Enhanced FMAP."

The Enhanced FMAP for a State for a fiscal year is "equal to the Federal medical assistance percentage (i.e., the State's Federal Medicaid matching rate[7]) increased by 30 percent of the difference between its regular Federal Medicaid matching rate and 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent. Thus, the Federal contribution to total expenditures is higher in CHIP, vis-a-vis the State contribution, than it is in Medicaid. For example, a State that pays 50 percent of its Medicaid costs (with the Federal government paying the other 50 percent) has an enhanced Federal match of 65 percent and is responsible for 35 percent of the new CHIP costs.8

None of the six States have drawn down their full Federal allocation of matching funds in the first year.

First, some States designed limited "placeholder" plans that are starting small. In addition, as is common with all new Federal public assistance programs, these States need time to fully implement CHIP. Considerable staff time and attention is required to plan, analyze data for program design, obtain State legislatures' approval, obtain Federal approval of official State Plans, design procedures and forms, select or expand on outreach strategies, collaborate with other public agencies and private organizations, and initiate or modify media campaigns . Implementing a new program must necessarily begin slowly, to allow time to test and redesign along the way, before full operation is feasible.

As a result, none of the six States are enrolling all eligible children or expending their full allotment of Federal funds in the first year. Even States with fully matured pre-CHIP health insurance programs cannot become fully operational in the first year or two. It has taken time for media campaigns and other marketing and outreach to succeed. States are, however, making concerted efforts to locate traditionally hard-to-reach populations, such as ethnic minorities and families living in rural areas.

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[6] Total allocations are approximately $4.3 billion for FY 1998-2001, decreasing to $3.2 billion for FY 2002-2004, and rising again through 2007.

[7] Medicaid matching rates vary by State. See Exhibit 3 for the six States' matching rates.

[8] Ullman, F., Bruen, B., and Holihan, J., *The State Children's Health Insurance Program: A Look at the Numbers,* The Urban Institute, Washington, DC, March 1998.

Exhibit 3 portrays the allocation of Federal matching funds and State matching rates.

Exhibit 3
Federal/State Financing FY98

	Federal Matching Funds Allocated	State Matching Rate
Alabama	$85.6 million	21 percent
Colorado	$42 million	34 percent
Massachusetts	$45 million	35 percent
New York	$257 million	35 percent
Ohio	$1 16 million	29 percent
Oregon	$40 million	27 percent

KEY PLAYERS AND ADMINISTRATION

Title XXI granted States considerable discretion to decide which agencies will oversee program administration, including outreach, eligibility determination, final enrollment, monitoring crowd-out, and collecting data for evaluation.

CHIP implementation and administration in the six States reflects a rich mosaic of State agency partnerships and collaboration with other State and county agencies, community organizations, advocates, and the private sector. Many States also rely on different types of advisory groups to recommend policies, program design, and phased expansions.

The individual case studies reveal the broad array of State agencies, county agencies, community organizations, advocacy groups and private sector organizations involved in design, administration, outreach, crowd-out prevention and data collection for evaluation.

Alabama

Lead agency: Department of Public Health
Key collaborators: State Medicaid Agency, State Employees Insurance Board, Department of Education, Children's Hospital, State Hospital Association, Children's Rehabilitation Services, State Medical Association

Colorado

Lead agency: Department of Health Care Policy and Financing
Key collaborators: Foundation for Children and Families (since, replaced by a private, non-profit contractor), Department of Public Health and Environment, Division of Insurance, Community Health Network

Massachusetts

Lead agency: Department of Health
Key collaborators: Department of Public Health, Area Health Education Center, Department of Transitional Assistance, Department of Education, Office of Child Care Services

New York

Lead agency: Department of Health
Key collaborators: New York Health Plan Association, Unemployment Insurance Division, Child Support Enforcement Office, Department of Education

Ohio

Lead agency: Department of Human Services
Key *collaborators:* 88 county agencies or non-profit organizations in those counties, Department of Health, Governor's Ohio Family and Children First Council, Bureau for Children with Medical Handicaps, Child Care Centers, Medical and School Nurse Associations

Oregon

Lead agency: Office of Medical Assistance Program
Key collaborators: Insurance Pool Governing Board, Office for Oregon Health Plan Policy and Research, 924 "community partners" representing a wide variety of State and local agencies and service providers

OUTREACH

Title XXI requires each State plan to describe its efforts to identify and enroll all uncovered children who are eligible to participate in public health insurance programs. By law, enhanced Federal matching funds for spending on administration (direct services, administration, and outreach and data evaluation) cannot exceed ten percent of the State's benefit expenditures. This limit may be waived by the Secretary, allowing the State to use more than ten percent for direct services, if these services are considered to be cost-effective. For States choosing to expand Medicaid, once they reach the ten percent limit for CHIP, they may only claim the regular Federal match rate for administrative expenditures.

HCFA stresses the importance of making enrollment as easy and accessible as possible for parents and communities. In a letter to State Health Officials, dated January 23, 1998, HCFA addressed the topic of outreach. For more information on HCFA's outreach directives, see http://www.hcfa.gov/init/children.htm and click on ***Letters to State Officials*** as well as ***Frequently Asked Questions and Answers.***

State Approaches

All six States combined Statewide and community outreach efforts. The result is a wide mixture of arrangements between public and private agencies as well as non-profit organizations and for-profit companies. Some outreach services are performed through contracts with the State's lead CHIP agency and some are in-kind donations.

- A State Department of Health coordinates the Statewide media campaign, but contracts local efforts to a "community outreach coordinator" who staffs a toll-free hotline for families and conducts a wide array of activities in communities. The private managed care plans actually enroll eligible children. (New York)

- A Department of Human Services maintains a toll-free Statewide Consumer Hotline and works with many State agencies to disseminate information to providers and families while individual counties develop and implement their own customized outreach plans. (Ohio)

- One lead State agency built upon existing relationships among other public agencies and private organizations to reach families as quickly as possible. Efforts were made to educate a wide variety of child-serving providers and specific professional audiences about the new program and mailings were sent to all public school districts. (Alabama)

- Another State agency combines outreach for both CHIP and its State-funded children's health insurance program and offers training seminars to a variety of participants, including private insurance agents, who have contact with uninsured families. (Oregon)

- A non-profit organization, under contract to the CHIP lead agency, conducts selected outreach activities. Its key feature is the use of Satellite Eligibility Determination sites in community locations where families can enroll immediately. Several sites now have the capacity to process applications through an electronic connection with the lead agency's central database; the Network plans to expand this capacity, which is expected to increase enrollments significantly. (Colorado)

- A State agency focused on moving children from a State-funded program into CHIP while local community groups received special grants from the State to help enroll hard-to-reach populations. (Massachusetts)

States conduct aggressive outreach when they have the fiscal resources to enroll all the children who apply. While some States can market CHIP to "find every eligible child," others must target the children they can enroll given the State's fiscal constraints.

- Four States' CHIP lead agencies have aggressive, multi-pronged marketing and outreach campaigns to find eligible children and enroll them. (Alabama, Massachusetts, New York and Ohio)

- Two other States' agencies have been more cautious about their outreach because their budgets limit the number of children they can enroll. In these States, other agencies organized CHIP outreach initiatives as part of their promotional efforts for other public children's health programs. (Colorado and Oregon)

States used the existing pool of children already enrolled in public health insurance programs to target their efforts to reach newly eligible children.

- Where Medicaid expansion is part of CHIP, staff sent mailings to households where some children are already covered by Medicaid to notify older siblings that they may now qualify. (Alabama and Massachusetts)

- Where there are existing State-funded programs, staff directed marketing campaigns at this known pool of children enrolled in them, to encourage parents to convert their children to CHIP. (Colorado, Massachusetts and Oregon)

A Seamless Health Care System for Children

State officials recognize the need to design an insurance system for lower income children that can accommodate changes in family circumstances that affect program eligibility. It is not uncommon for children's eligibility to fluctuate between Medicaid, CHIP, private insurance, and/or State-funded programs when employment, family income, or other circumstances change. All six States have taken steps to ensure that children have the continuity of health care that they need.

States simplified application forms and eligibility determination processes for multiple programs.

- ❖ All States developed a simplified, integrated application that is used for both the CHIP and Medicaid programs.
- ❖ Two States use the same application for the Special Supplemental Food Program for Women, Infants and Children (WIC). (New York and Ohio)
- ❖ One State's application also enrolls children for Children and Family Health Services and Bureau for Children with Medical Handicaps. (Ohio)
- ❖ Four States allow families to mail in their CHIP applications so there is no need to go to a government office. (Alabama, Massachusetts, Ohio and Oregon)
- ❖ Five States provide a Statewide toll-free telephone number for families to call where trained personnel help them complete applications. Three of them mail applications to families to sign, attach necessary documentation, and return by mail for processing. (Ohio, Oregon and Alabama, where families receive a postage-paid envelope to return the signed application.)
- ❖ In one State, information from the integrated application is entered, and an automated decision tree places the children in the appropriate public health insurance program depending on the family income and insurance status. After qualifying, families get an information package in the mail to select a managed care plan. (Massachusetts)
- ❖ To expedite enrollment in Phase I, a new simplified Medicaid application was developed to add CHIP-eligible teenagers living in families where other children are already enrolled. (Alabama)

States offer presumptive and continuing eligibility to help ensure the continuitv of health care.

- ❖ Four States (all but Alabama and Colorado) offer variations on presumptive eligibility during the time it takes the State to process applications.

- ❖ All States offer continuing eligibility. Oregon and Ohio provide it for six months while the others offer it for 12 months.

Collaboration Among Public and Private Agencies

All six States are organizing creative collaborations to market CHIP to eligible families. The CHIP lead agencies have entered into innovative public-private partnerships and are also forging new relationships with other State agencies, private organizations and provider networks.

CHIP lead agencies created new public-private partnerships to help market the program and to enroll eligible children by contracting with non-profit or for-profit organizations.

- ❖ In two States, a second State agency, under contract to the lead agency, helps administer CHIP. In one of those States, a State Employees Insurance Board serves as the enrollment broker. SEIB has experience managing another health benefit program in the State so it was well-positioned to help with CHIP. SEIB hired and trained staff to answer questions and take applications over a Statewide toll-free telephone number. (Alabama) In a second State, the Insurance Pool Governing Board, which administers several other health insurance subsidy programs for low-income individuals, has taken responsibility for marketing, evaluation, and outreach to children in families likely to be CHIP-eligible. (Oregon)

- ❖ An actuarial analysis firm, under contract to the CHIP lead agency, provided assistance when the State designed the RFP for private vendors and helped assess bids that were received after it was issued. The firm had previous experience working in the State's insurance market and was also familiar with child health insurance programs in other States. (Alabama)

- ❖ A community outreach coordinator, under contract to the lead agency, attends local events across the State and organizes a variety of activities to educate the public about children's health insurance programs. Numerous promotional materials are used as part of the public education effort: bumper stickers, Frisbees, refrigerator magnets, and sun visors. The outreach coordinator also staffs a Statewide toll-free number for families to call for information about available benefit programs. Families select a health plan for their children and the plan enrolls them. All participating plans must submit a marketing and enrollment plan to the

Department of Health for review and approval prior to implementation. (New York)

- A foundation, and later a private, non-profit organization, under contract to the State oversight agency, administers the CHIP program. Its staff conducts marketing, handles customer services, processes applications, finalizes enrollment, develops the management information system, analyzes data on outreach, and also maintains the provider network. (Colorado)

CHIP lead agencies coordinated outreach with a variety of State agencies to reach large numbers of potentially eligible children.

- The collaborating agency staff sent notices to food stamp recipients and the State Medicaid agency placed inserts about children's health insurance programs in Medicaid denial notices (Oregon)

- The Department of Transitional Assistance provides the Division of Medical Assistance with lists of families recently terminated from the time-limited welfare program. DMA notifies these families about their continued eligibility for Medicaid, which they often do not know about. (Massachusetts)

- A lead agency mailed information to 85,000 WIC households inviting them to call the Consumer Hotline and/or apply for public children's health insurance programs, which generated a tremendous response. (Ohio)

State Education departments and local school districts are critical outreach partners.

- All school superintendents received an informational mailing about the program that also described available outreach materials. At the local level, the outreach coordinator arranged for materials to go home with students, including with report cards. (New York)

- Immediately after Phase II began, all school-age children received a program brochure and application with a self-addressed stamped envelope to return to the enrollment broker. Over 750,000 applications were distributed. (Alabama)

- The Department of Education and Office of Child Care Services play major roles in the State's annual school-based outreach effort to provide information through every public and private school and every child care program in the State. (Massachusetts)

- Thousands of applications and brochures were sent to school district contacts. Program staff report that nearly one-third of callers to a Statewide phone bank report hearing about CHIP from their children's school. Orientation sessions were held in school districts identified as having a large percent of children enrolled in the school lunch program. (Colorado)

CHIP lead agencies coordinated outreach with other State health agencies, especially when CHIP includes expanding Medicaid.

- One lead agency worked with the medical assistance agency to mail notices to all 300,000 Medicaid households and all 10,000 Medicaid managed care providers. Brochures were distributed widely, especially to outstationed Medicaid workers who are placed in county health departments, hospitals, clinics and community health centers. These outstationed workers are electronically connected to the State Medicaid computer system to expedite the eligibility process. (Alabama)

- CHIP outreach was incorporated into on-going efforts by public health nurses to educate families about other child health initiatives. (Colorado)

- Two States' lead agencies mounted a major effort to move thousands of children enrolled in the State-funded children's health insurance program into the CHIP. Families received letters, with an application, that explained their potential eligibility for the new program and described its advantages. In one of these States, families who did not respond to the letter were personally contacted by specially trained college students who made calls at night or over the weekends when families were most likely at home. (Massachusetts) In the other State, families'- that did not respond to the mailing or did not agree to switch programs were permitted to maintain their enrollment in the old program for one year beyond their enrollment date. (Colorado)

CHIP lead agencies relied heavily on a wide variety of child-serving providers, including health professionals.

- Two free, live satellite video conferences were produced by the CHIP lead agency. They were available for viewing at county health departments and other facilities with satellite downlinks in multiple sites on two different dates. Copies were also distributed to those who could not attend the live broadcast. The video was viewed by educators and school guidance counselors; social workers; hospital staffs; different medical professionals; child care providers; social service workers; and clergy. The lead agency also produced videos for five special professional audiences who see potentially eligible children. (Alabama)

- Agency staff conducted more than 100 training seminars at a variety of locations where uninsured families are most likely to visit or live. Seminars last half a day and are well attended by a variety of "community partners" who have contact with uninsured families. Community partners include representatives from State agencies; community action agencies; WIC programs; school districts; service agencies for homeless families, and youth shelters. Over 900 private insurance agents also attended. (Oregon)

- A CHIP lead agency sent a mailing to nearly 12,000 licensed home-based and center-based child care facilities to inform both families and child care providers who may not have health insurance for their children. (Ohio)

- A non-profit organization (the Children's Health Network) conducts outreach through Satellite Eligibility Determination sites. These 36 sites (and nine more are planned) are located in various community settings, such as school-based health clinics and community health centers, where eligibility is determined immediately. Five sites process applications through a computer link to a central database, and by late 1999, half the sites will have the computer link. To educate child-serving professionals, training sessions were held in local communities to teach participants how to help families complete the application. Over 800 people participated including: public school nurses, social workers and psychologists; EPSDT workers, Family Resource Center and Head Start staff, and school-based health center staff. (Colorado)

- The Community Partnerships Initiative was developed by the CHIP lead agency to identify and disseminate information and applications through key community stakeholders. Partners included school nurses, municipal skating rink directors, librarians, summer camp directors, public housing directors, civic and neighborhood association leaders and others. (Massachusetts)

- In three States, CHIP lead agency staff worked closely with different medical associations by offering seminars to explain the program, sending informational packets and using their newsletters. A Children's Hospital provided information through its Sports Medicine Clinic to reach uninsured teenagers. It also reviewed its records to identify all uninsured children seen over the past 18 months and sent them letters explaining the new program along with an application package. (Alabama, Massachusetts, Ohio)

Some CHIP lead agencies target outreach for children with special health care needs.

- One lead agency is coordinating discussions among the appropriate agencies to develop CHIP/Phase III, to address the special needs of children with disabilities and chronic health conditions. The State Children's Rehabilitation Services (CRS) identified children in its program who are uninsured and contacted their families to explain the new program. CRS pays CHIP premiums and co-payments for children in its Children with Special Health Care Needs program, because it is more cost-effective to provide this primary and preventive care than to face the higher specialty costs that may later be incurred. With the projected savings due to ALL KIDS and CHIP coverage, CRS reintroduced services to these children that were previously eliminated because of funding cutbacks. (Alabama)

- Another State added questions to the application, expressly designed to refer children with special health care needs to that program and to the Supplemental Security Income (SSI) program. (Colorado)

- One Bureau for Children with Medical Handicaps sent informational mailings to families already enrolled in BCMH families as well as those now applying or having a recertification. The mailing explained CHIP and directed the families to call the Consumer Hotline to begin the enrollment process. (Ohio)

Marketing to Hard-to-Reach Populations

All States expressed concern about locating under-served populations and recognized the need to customize strategies for different cultural and ethnic populations.

States recognize the need for local groups to conduct outreach in their own communities, in order to customize marketing approaches and materials to discrete hard-to-reach populations.

- Three State agencies in one State contribute funds to support a competitive mini-grant program. The program targets organizations that have successfully demonstrated their ability to serve their communities, especially hard-to-reach families who would not otherwise have health insurance coverage. The mini-grant program awarded grants to 5.2 organizations last year. The grants, which range from $5,000-$20,000, were awarded to community health centers, housing groups, child care agencies, immigrant and refugee service programs, and hospital community programs. Mini-grant recipients attend monthly regional Health Access Networks, along with other health-related community groups, to meet with local and State public agency staff to share information and develop linkages to facilitate outreach. (Massachusetts)

❖ One State is developing a "facilitated enrollment" process to assist families applying for Medicaid or CHIP. Community workers will help families through the application process by screening them for the appropriate program, completing the application, collecting required documentation and submitting the application to the appropriate organization for eligibility determination. The goal is to recruit facilitators who work in a variety of community settings (e.g., child care, social services, schools) and who speak different languages, among the diverse populations. (New York)

States recognize the need to provide accessible information for bilingual families.

- 3 A simplified, unified application will soon be available in English and Spanish. (Ohio)

- 3 Staff developed brochures, posters, enrollment packets and benefit booklets in Spanish and English. They plan to expand and enhance a toll-free Family Health Line to add Russian and Southeast Asian languages to the current Spanish and English translation capabilities. (Colorado)

❖ The League of Community Health Centers promoted child and family health insurance enrollment through an English/Spanish poster campaign. (Massachusetts)

States recognize that certain populations need more individual attention.

❖ Staff met with fishing families in eight coastal communities to inform them about the public children's health insurance programs. In addition, they attended conferences for two Native American tribes and held Rural Health Forums across the State. (Oregon)

❖ Staff consulted Native American tribal representatives about how to best inform families about public health insurance. Tribal members want to develop fact sheets for health care providers to explain specific cultural beliefs about health that affect how certain medical conditions are prevented or treated. (Alabama)

❖ Staff held a series of Statewide meetings with Latino community leaders to increase awareness about the availability of public health insurance and develop effective outreach and marketing strategies for Latino neighborhoods. (Massachusetts)

❖ Public health nurses go door-to-door in trailer parks and many of them reach deeply into rural parts of the State. (Colorado)

- One CHIP lead agency sent a mailing to approximately 13,000 individuals affiliated with the State Council of Churches. They also worked with the Commission on Minority Health to notify many minority clergy about the program. (Ohio)

All States use print and electronic media as part of their public education, especially to reach families living in rural areas and those who rely on their own ethnic newspapers or radio/television stations.

- A public relations firm, under contract, was hired to generate continuous media coverage for the CHIP program. The firm is expected to develop newsworthy stories about participating families, providers and prepare press releases to cultivate and maintain interest in the program. Ads were placed on 40 Hispanic radio stations(Colorado) and a Public Service Announcement was developed for a Latino television station. (Massachusetts).

- A media event was held on the steps of the State Capitol when the new State program began. It was broadcast to eight sites around the State where press conferences, hosted by members of the State Hospital Association, were held to promote CHIP in the local community. (Alabama)

- One Department of Health runs a major Statewide media campaign. State officials believe radio and television ads were most effective because they reach large segments of the general population. (New York)

- Public service announcements were developed for a Latino television station. (Massachusetts)

- Most States ran television and radio ads, prepared news releases and camera-ready copy for newspapers.

Outreach Funding

States are using different funding sources to cover their outreach expenses.

- One State allocated most of the Medicaid eligibility outreach funds, available through the Temporary Assistance for Needy Families (TANF) block grant, to counties based on the number of their potentially eligible Medicaid individuals. To receive the outreach funds, county stakeholders (e.g., local Department of Health, country departments of human services, advocacy organizations) had to develop an outreach plan through a collaborative process. Counties were also required to provide matching funds. (Ohio)

- Two State agencies in one State allocated funds for the mini-grant program designed to find hard-to-reach families. These funds are a mixture of Medicaid, Title XXI and TANF block grant dollars. (Massachusetts)

- Using Title XXI funds, the State will significantly supplement its outreach budget to fund facilitated enrollment in local communities across the State. (New York)

States are allocating outreach funds for a variety of activities or program-related expenses.

- Half the States expect to exceed the ten percent cap on enhanced matching funds for administration because of outreach expenditures. (Alabama, Colorado, and Oregon) Colorado projects those expenditures will reach 16 percent of total expenditures in the first year, for outreach and other administrative costs.

- Most outreach funds were spent to print and distribute date-stamped application forms and to provide training for community partners around the State. (Oregon)

- Most outreach funds were spent to print 1.5 million program brochures, applications and return envelopes with postage paid. The agency made a conscious decision to use an attractive color brochure that makes the CHIP program look different from a typical government program. (Alabama)

- In one State, the primary expenditure for outreach is the contract with a private, non-profit organization (formerly a foundation). In addition, a $75,000 grant for outreach was awarded to the Children's Health Network from the Federal Health Resources and Services Administration. (Colorado)

Woodwork Effect

Some agency officials and legislators worry that vigorous outreach for public insurance programs will draw more eligible individuals "out of the woodwork" than originally projected, and drive costs beyond anticipated levels.

Many States are using CHIP to surface children eligible for Medicaid, as well as CHIP. Some are concerned about the effect of CHIP outreach on Medicaid growth. Still others are concerned about exceeding initial target enrollments for CHIP, itself.

- State agency staff in two States worry about creating more demand for CHIP than they can respond to and having to start waiting lists. They are also concerned that CHIP outreach will locate more children who are Medicaid-eligible, which will significantly increase State costs. (Oregon) In another State, there was similar concern during the first seven months of implementation, but that concern has abated since enrollments are falling short of the target. Staff in both public and private agencies disagree about whether aggressive outreach will produce CHIP waiting lists. Although the State budget limits how many children can enroll, some staff believe that the cost sharing requirements deter enough families so that target enrollment numbers are not likely to be reached. (Colorado)

- As a result of outreach efforts for the non-Medicaid CHIP program, applications for Medicaid soared. Although Medicaid staff anticipated that CHIP outreach would increase enrollment, the agency was surprised by how quickly families responded and how large a backlog of applications it created. (Alabama)

- CHIP lead agency staff, by design, planned a Medicaid waiver demonstration project to attract many families who were previously eligible for, but not enrolled, in Medicaid. They estimate that two of every three families applying this past year fall into that category and hope that CHIP outreach will have the same effect. (Massachusetts)

- State officials recognize that a woodwork effect may result from its aggressive efforts to identify uninsured children who may qualify for CHIP or Medicaid. They want to encourage eligible children to enroll in Medicaid by reducing its stigma and making the application process more convenient for the family through a newly facilitated enrollment process. (New York)

CROWD-OUT PREVENTION

Congress has a longstanding concern about whether Federally subsidized health insurance programs unintentionally encourage families to substitute free or low-cost public insurance for their existing private health coverage. In addition, Congress is concerned that the increased availability of public insurance through CHIP may encourage companies to drop coverage for their employees or dependents. This concern about whether public insurance will substitute for private coverage is commonly referred to as "crowd-out." Congress is also concerned about another potential form of crowd-out — that States may substitute CHIP coverage for Medicaid coverage in the face of the enhanced Federal matching rate for CHIP. With the passage of Title XXI, Congress expressly directed States to guard against crowd-out and, where necessary, adopt measures to prevent it.

Employee crowd-out occurs when families drop employer-provided insurance coverage altogether, or disenroll their children in the dependent portion of that coverage, in order to enroll them in public insurance. It may also occur with families already enrolled in public health insurance who obtain a job with employer-provided dependent coverage, but do not switch their children to that coverage.

Employer crowd-out occurs when employers cease offering health insurance, or cease offering dependent coverage, because they believe the children could be enrolled in public insurance plans. It may also occur where employers might otherwise offer health insurance with dependent coverage (especially new businesses) were it not for their awareness of public health insurance available for children.

Some State officials believe that *employee* crowd-out is not a genuine concern, at least until the income eligibility levels for public insurance reach at least twice the Federal poverty level. Officials often point to a study in Minnesota[9] that documented little to no crowd-out.[10] Others believe that some small amount of crowd-out is a price the nation should be willing to pay in exchange for providing low-income children with health insurance that provides access to medical care.

According to the Institute for Health Policy Solutions, little is known about what policies effectively reduce crowd-out. Only a handful of States have State-only programs that pre-date CHIP and offer comprehensive health benefits coverage for children in families with incomes up to 200 percent of poverty. Even fewer have

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[9] *Private* Market *Crowd Out and* Minnesota *Care:* Evidence *fo Date,* Minnesota Department of Human Services, July 1998, p. 4.

[10] Other researchers caution that Minnesota's experience is not a good case in point. The State adopted extraordinary crowd-out prevention policies that no other State has so far adopted. For example, applicants are not eligible if (1) they now have access or had access to employer-subsidized insurance during the 18 months prior to applying or (2) had any health insurance in the four months prior to applying.

implemented direct measures intended to reduce crowd-out. Further, no empirical evaluations have been conducted of programs that have adopted these measures.11

There has been no research on employer crowd-out. There is, however, a national trend towards reducing employer-provided health insurance — a trend that has not yet been correlated with growth in public insurance programs for low-income children. This trend is evident in all of the case study States, except Oregon.

"Title XXI requires that every State Plan include a description of procedures to ensure that the insurance provided by CHIP does not substitute for coverage under (private) group health plans." Policy options identified by States to mitigate or prevent crowd-out include:

- Setting the ***income eligibility level (percentage of Federal Poverty Level)*** low enough so as to attract families unlikely to have been covered by employer insurance;
- Adopting ***waiting periods*** before families previously covered by employer insurance can qualify;
- Adopting ***cost-sharing provisions using premiums an&or co-payments*** for families with higher incomes, to mirror the private/employer insurance market;
- Imposing ***lock-out periods*** on families failing to pay their premiums;
- Subsidizing the families' premiums, called ***employer buy-in,*** for employer-provided dependent coverage, under certain circumstances approved by HCFA.[12]

In States with CHIP Medicaid expansions, Title XXI requires that a State: must assure that it will coordinate its program with other public and private programs; may not make its Medicaid eligibility requirements stricter (to crowd children out of Medicaid and into CHIP to claim the enhanced matching rate) than those already in place on June 1, 1997; and must screen CHIP applicants for Medicaid eligibility and enroll them in the latter, if eligible.

On February 13, 1998, HCFA issued guidance for States intending to use CHIP funds to subsidize employer-sponsored group plans. They must develop provisions for their plan that are equivalent to the following:

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11 Hearn, Jean, *Coordinating* Children's Coverage *Expansions with Employer-Sponsored Coverage,* Institute for Health Policy Solutions, Washington, DC, March 1998.

12 February Letter HCFA.

- ensure that coverage is targeted to children whose families were previously unable to afford dependent coverage — Children cannot qualify for subsidies through an employer sponsored group health plan if the family had coverage for them within the previous six months. States can require a longer period of uninsurance, but no longer than 12 months. Exceptions are allowed if the prior coverage was involuntarily terminated. Newborns who are not covered by dependent coverage would not be subject to any such waiting period.

- discourage employers from lowering existing contributions for dependent coverage-States can only provide subsidies to purchase dependent coverage through employer-sponsored group health plans when the employer contributes at least 60 percent of the cost of family coverage, the median employer contribution nationwide. HCFA will consider a somewhat lower level if states have additional provisions to limit employers' ability to lower contribution levels.

- ensure that providing child health coverage through employer-sponsored group health plans is cost effective and that the state is not inappropriately subsidizing coverage for adults in a family-States cannot pay more for a child enrolled in an employer-sponsored group health plan than what it would spend if the child was enrolled in a separate CHIP plan or Medicaid.

- promote cost effectiveness-Families electing to receive child health assistance through an employer-sponsored group health plan must apply for the full premium contribution available from the employer.

- demonstrate cost effectiveness-States must collect information and conduct an evaluation that examines the substitution (if any) that has occurred under the program and the effect of these provisions on access to the program.

The six case-study States adopted a variety of policy options to prevent employee crowd-out. Some State officials dismiss employee crowd-out as a problem, especially where a pre-CHIP program was operating that showed no evidence of crowd-out. They adopted one or two policies, nevertheless, because the statute requires it. One State is taking a wait-and-see policy. Other State officials are concerned about employee crowd-out and adopted multiple policies to prevent it.

Some officials were sanguine about employee crowd-out, but genuinely concerned about employer crowd-out. One State is subsidizing employers' premiums with the goal of sustaining employer-provided health insurance for children and attracting more small employers into the employer-provided insurance market.

Setting the FPL level

- One State expressly pegged its CHIP income eligibility level at 185 percent FPL in an effort to avoid crowd-out. This FPL level is also used for the State's pre-CHIP health insurance program where officials do not believe that any crowd-out has occurred. (Colorado)

- In another State, some concern about crowd-out affected the decision to cap the CHIP program at 250 percent FPL. (New York)

- The other States did not cite the FPL level as a crowd-out prevention strategy. Two States are simply expanding Medicaid to older children for Phase I (Alabama and Ohio). Another State moderately raised the FPL level for CHIP/Medicaid so employee crowd-out in families with moderate income is not viewed as an issue. (Alabama)

Waiting Periods

Waiting periods are policies that require families currently enrolled in, or who recently dropped, employer coverage to have no coverage for some months before their children qualify for CHIP. Waiting periods are sometimes also called "look-back periods." Some States have raised equity concerns about waiting periods: should the waiting period for eligibility apply to families currently or recently insured or should it also apply to those with *access to employer coverage* that chose not to enroll?

Four States use waiting periods as an explicit strategy to prevent employee crowd-out. They only apply the waiting periods to children currently or recently insured by employers. (Alabama, Colorado, Ohio (Phase II), Oregon) Three States use a three-month waiting period (Alabama, Colorado and Ohio) while another uses six months. (Oregon)

One State currently has no waiting period, but is monitoring quarterly information. If evidence shows that CHIP is substituting for private coverage in excess of eight percent, then the State will impose a six month waiting period. (New York)

In two States, the equity issue was debated.

- One State chose to apply it only to the currently or recently insured because policymakers determined it would be too complex to assess the *potential* availability and affordability of workplace health insurance for families. (Colorado)

- In the other State, the discussion among State agency officials, a policy council, and advocacy organizations was particularly contentious because the proposed waiting period was six months. However, a small majority prevailed and the six month waiting period is not imposed on families who have access to, but never enrolled in, employer insurance programs. The decision was made for reasons similar to those in Colorado. (Oregon)

Cost-Sharing

Four States impose premiums on families at graduated levels depending on family income (Alabama, Colorado, Massachusetts, New York). Two of these States also require co-payments.

A Task Force planning Phase II/CHIP recommended that the legislature impose both premiums and co-payments. The issue will be debated as part of the legislature's biennial budget for State fiscal years 2000 and 2001. (Ohio) See Exhibit 4 for cost-sharing levels.

Loc k-out Periods

When States use premiums as a crowd-out prevention strategy, they may impose lockout periods as a sanction against families who fail to pay their premiums. A lockout is a period of time when children are excluded from coverage, or disenrolled by the administering agency, for an arrearage in premium payments.

Two States impose lockout periods.

- Families who fail to pay receive three written notices and a 30-day grace period. Continued failure to pay excludes the children from CHIP for six months. (Colorado)

- Families who are in arrears for two months are locked out of CHIP for one year. There are, however, special hardship provisions. (Massachusetts)

Alabama has no lockout period, but children cannot re-enroll for a new year if premium payments are not current.

Employer Buy-in

Title XXI permits States, under certain circumstances, to "buy in" to employer insurance, by subsidizing employee premiums.

Insert Exhibit 4 Here

Among the six States, three have or are planning a program to help employees buy in to employer insurance by subsidizing their premiums. One State's program is operating while two others are planning pilot programs later in their CHIP implementation.

- In one State, officials believe that employer and employee subsidies offer the most effective way to discourage further erosion of employer-sponsored health insurance. Under a Medicaid waiver, the State's Insurance Reimbursement Program (IRP) provides premium assistance payments for families (and individuals) with incomes below 200 percent FPL. The IRP also offers incentive payments for small employers who provide insurance to lower income employees and pay at least half the premium cost. The program will begin with companies of less than ten employees and expand to those with less than 50 employees. (Massachusetts)

Two States want to pilot programs with a purchasing cooperative of employers.

- In one State, officials are working with HCFA to develop an employer buy-in program. In December 1998 they were developing a "white paper" raising the issues and questions that must be answered in order to select program features. The current plan would pilot the program with a purchasing cooperative of employers who offer a standardized benefit package. (Colorado)

- In another State, officials may request HCFA's permission, in a Phase II Plan Amendment, to pilot an employer buy-in program. They would work with the State's only health insurance purchasing cooperative to market CHIP to employers for eligible families who are not enrolled in their employer's plan. (Oregon)

Data Collection and Evaluation

In order to insure' that State programs are effective and are reaching the intended populations, States need to collect information and report back to the Federal government on their progress. Evaluations for States with approved plans are due to the Secretary by March 31, 2000. The evaluation will include (but is not limited to) discussion of: the effectiveness of the program in reducing the number of uninsured children in the State; the characteristics of the population being served; quality of services; coordination with other public and private health care programs; analysis of changes that may affect access to coverage; and recommendations for improving the program.

In addition, States must submit annual reports every January. On a quarterly basis, States must report expenditure data to support their claims for federal matching funds and financial/statistical data for program monitoring and evaluation purposes. States are required to collect data in the following areas:

- Expenditures;
- Number of children enrolled by age group;
- Number of children by income categories;
- Baseline estimate of the number of uninsured children in the State.

The six case study States are now refining their CHIP data collection and evaluation efforts. Several States reported that their efforts initially focussed on establishing the program and the requisite administrative infrastructures so they are only now turning their attention to data collection and evaluation. Several States recommended that data collection and evaluation efforts be planned in the initial program planning. This was often something that they were not able to do due to the quick turnaround in launching their CHIP programs.

Data Used for Program Design

All six States are collecting and reporting the required data. However, baseline estimates of the number of uninsured in the State will be difficult for some States to obtain.

The sample size used by CPS is considered too small to accurately estimate the number of uninsured in most states. In some cases CPS data were used in conjunction with other data collection to provide more precise estimates. In other cases, estimates were achieved through State-sponsored surveys.

- The lead agency in one State and a University are collecting data on the number of uninsured in the State. Regional estimates on the number of uninsured are being compiled using data already available from surveys conducted by the agency, the University, and the Urban Institute. (Massachusetts)

- One State is estimating the number of uninsured by using CPS data to project county estimates of uninsured, taking a three year average of the 1995, 96, and 97 March supplement to CPS. (Colorado)

- One State contracted with a private consulting firm to study the number of potentially eligible individuals. Using CPS data, a model was created to estimate the number of potentially eligible individuals under 150 percent FPL. (Ohio)

- By using data collected in a State population survey, one State developed estimates of the number of uninsured adolescents, which bolstered the case for expanding public health insurance to children through age 18. (Oregon)

- A State Legislature mandated a study of uninsured individuals to provide estimates of the uninsured at the sub-state level. (New York)

During the planning phase, States relied on data from a variety of sources to make decisions about program design.

- One State relied on data from a study of uncompensated care as well as a separate study designed to compare various approaches to cover uninsured working families. (Massachusetts)

- A study that compared the quality of care and utilization of the earlier State-funded children's health plan to Medicaid and private health insurance was used to advocate for certain features of the current CHIP program (Colorado).

- One State used Statewide forums to gather qualitative information about community priorities while planning their CHIP Medicaid expansion. After the expansion, forums were used again to get feedback on expanding eligibility to children to 200 percent FPL in Phase II. (Ohio)

- Findings from a study of health insurance in 13 States, which included both a household and employer survey, were used to recommend the six month waiting period in CHIP for those who are already insured. (Oregon)

CHIP lead agencies contracted with private actuarial companies to help establish reimbursement rates for the program. (Alabama, Colorado, Ohio)

Data Used for Program Evaluation

States added questions to their CHIP applications or to existing surveys to collect specific information about the CHIP program.

- 3 In order to analyze the effect of the six-month waiting period on potential CHIP eligibles, agency officials will analyze special items that were added to the CHIP application form. (Oregon)

❖ Questions designed to measure crowd-out were added to one State's application. If evidence emerges that CHIP is substituting for private health coverage in excess of eight percent, then the State will impose a six month waiting period. (New York)

❖ One State added questions on the joint CHIP/Medicaid application to identify if children are successfully referred to the Health Care Program for Children with Special Needs and SSI. (Colorado)

❖ Questions were added to the CDC Behavioral Risk Factor Survey and a State Health Survey to collect data specific to CHIP. (Alabama, Ohio)

CHIP lead agencies are monitoring outreach through toll-free hotlines used by families to apply.

❖ Phone bank operators ask how applicants heard about the program and report the information back to those responsible for outreach. Agency personnel can often quickly assess the impact of high-visibility outreach campaigns through hotline usage. (Colorado, Ohio) Collaborating agency staff analyze reservation cards and applications and conduct surveys to gauge the success of discrete outreach activities. (Oregon)

States are measuring quality of care by collecting claims and encounter data as well as consumer satisfaction surveys.

❖ One State receives performance data from the participating health plans. The information describes the population served, utilization, quality, access, and consumer satisfaction. (New York)

❖ One State Medicaid agency provides claims information to a company that will format the data so that the lead agency can evaluate enrollment, claims and encounter data as well as quality measures (HEDIS) (Alabama).

❖ The claims system in one State captures which services are provided by managed care organizations across the State. The Medicaid agency can then match encounter data to eligibility files to examine access and quality measures for specific populations. (Massachusetts)

❖ One State is expanding efforts to measure the quality of care to include CHIP. The State is studying client satisfaction surveys, and analyzing HEDIS data on utilization, access, and quality. (Colorado)

❖ One State is evaluating the quality of care provided by CHIP by reviewing medical records, conducting consumer satisfaction surveys, and analyzing claims data against standardized quality measures. (Ohio)

● 3 One State is using a Consumer Assessment of Health Care Survey to collect information about access to and experience with quality of care. The survey, in English and Spanish, is mailed directly to individuals to complete. (Massachusetts)

❖ One State CHIP lead agency receives monthly reports from its community outreach coordinator. These reports have demographic information and also indicate how families heard about CHIP so the agency can evaluate its outreach strategies. (New York)

Other Data Collection Methods

Three States are conducting their own population surveys in order to gather comprehensive information about health care, monitor health care trends, and evaluate the impact of changes in health care.

❖ One State has surveyed 16,261 households with questions on various aspects of health care including insurance coverage, health care utilization, and income level. Where appropriate, the 20 minute phone survey included questions about a child in the household. The State department of Health took the lead on the survey but collaborated with various State agencies and a University to develop the survey instrument. Certain geographical areas and subgroups were over sampled to provide better estimates. Counties in the State were invited to purchase additional surveys. The State Department of Health is providing some analysis to the counties but is also making the data available to the counties to conduct further analysis. (Ohio)

❖ One State has developed a population survey that has been administered every two years since 1994. The survey includes 5,000 households of approximately 14,000 individuals. The survey includes questions about employer-sponsored insurance, and current health insurance coverage. Agency staff plan to analyze the CHIP penetration rate from the survey

results. They also plan to use data from the population survey and a State-sponsored survey of employers, as well as questions on the Medicaid/CHIP application, to analyze employee crowd-out. (Oregon)

- One State is currently designing a comprehensive study of uninsured individuals that will be fielded in November 1999. (Massachusetts)

CONCLUSION

The foregoing analysis focuses on one. point in time in the early implementation of CHIP in only six States. That time is the late fall or early winter of 1998/99. In the process of sending draft case studies back to the States for review and fact-checking, some changes in policy and practice were revealed in a couple of States. Since that time and the publication of this report, there are likely to have been changes in the other States, as well.

This report describes briefly the history of child health insurance programs prior to CHIP in the six States, the locus of administration and collaboration with other public and private administrative entities, and federal/state financing, then focuses the remainder of attention on outreach strategies, crowd-out prevention policies, and data collection and analysis plans.

The cross-case analyses in this report, and the case studies from which the analyses draw, are based on six States that are not necessarily representative of all the States. Nevertheless, these States were selected from those approved as of June 1998, to represent a mix of program options (state-initiated program vs. Medicaid-expansion, or a combination), income eligibility levels, existence of pre-CHIP State health insurance programs, geographic distribution of the States, and demographic mix of the population. As such, their policies, practices and experiences are likely to be found in many other States. Thus, some general conclusions can be drawn from these States about the early implementation of CHIP.

States are moving aggressively in the variety, scope, and intensity of their marketing and outreach campaigns to find and enroll both children eligible for but not enrolled in Medicaid, and enroll them in Medicaid, and children eligible for CHIP. The campaigns are both broad-based and targeted to find children among traditionally hard-to-reach families. Statewide mailings and media campaigns are supplemented with targeted outreach to families in deeply rural areas of the States, ethnic minorities, children of foreign-born parents, Native American children, and families known to be traditionally resistant to enroll in government programs. And the most significant feature of States' outreach strategies appears to be the broad collaboration with other public and private agencies and organizations.

Crowd-out is not universally embraced as a problem. This is especially the case in the five States with pre-CHIP health insurance programs for low-income children, where staff assert that no credible evidence of crowd-out emerged. Moreover, advocacy organization staff and other researchers note that the adoption of crowd-out prevention policies (e.g., waiting periods and cost-sharing) may thwart the very policy for which Congress adopted CHIP — reduction in the numbers of low-income, uninsured children in the United States. Nevertheless, five States adopted at least preliminary crowd-out prevention methods. The sixth State is

taking a wait-and-see approach, carefully monitoring for the potential emergence of crowd-out, and planning to adopt prevention methods if it exceeds a threshold level.

Finally, data collection for the evaluation of CHIP's outcomes is nascent. For the most part, States took quick advantage of the availability of Title XXI funding to expedite planning, program design, operational decisions, State Plan submittal and approval, and to vigorously undertake outreach, application processing, and enrollment. At the time of the State visits for this study, data collection was beginning. Perhaps the most developed data collection and analysis activities are those in the two States that have population surveys that include questions on health insurance coverage and access to care. But those surveys are not specific to CHIP, as they were initiated at least one year prior to CHIP implementation.